

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION          |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>TN4401</b>                               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>08/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MABRY HEALTH CARE</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1340 N GRUNDY QUARLES HWY</b><br><b>GAINESBORO, TN 38562</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                     | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| N 000  | Initial Comments<br><br>Complaint investigation #TN00054967 was<br>completed on 8/17/2021 at Mabry Health Care.<br>No deficiencies were cited under Chapter<br>1200-8-6, Standards for Nursing Homes. Census<br>51. | N 000  |  |  |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE